DEFENDANT'S EXHIBIT
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Vermont Psychiatric Care Hospital Procedure	
Admissions	
Revised: X	Date: 04/07/14

PURPOSE:

To ensure that admission practices are standardized to be efficient, trauma informed, and to promote a safe and helping environment.

CONSIDERATIONS/REQUIRED STEPS:

At admission the following steps shall be followed:

1. All patients admitted to Vermont Psychiatric Care Hospital (VPCH) shall be assessed for risk of harm to self or others.

2. All patients admitted to VPCH will be evaluated by the admitting physician regarding the need for any accommodation for any disability and/or interpretation services for non-English speaking or hearing impaired patients. *See also Services to Deaf and Hearing Impaired Patients Policy and Procedure, and Limited English Proficiency Policy and Procedure.*

3. As the patient is admitted or received to the unit, s/he will be searched and scanned for dangerous objects. *See Restricted Items and Search Policy and Procedure, and Patient Personal Belongings Policy and Procedure.*

4. A physician shall evaluate each patient at the time of admission and document the assessment in the patient's medical record within 24 hours.

5. For new admissions, the admitting nurse can participate in the admission interview with the admitting physician. The nursing assessment is begun at this time. Nursing assessment includes recording vital signs.

6. All newly admitted patients shall receive a copy of the Notice of Patient Rights, the Notice of Patient Privacy Practices and the VPCH Patient Handbook, which includes information on the VPCH grievance procedures.

7. All patients shall be asked if they have or have interest in an Advance Directive. If the patient indicates an interest in an Advance Directive, information shall be provided. *See Advance Directives Policy and Procedure.*

8. Upon admission or at the earliest reasonable time, with the patient's permission, staff shall work with the patient and his or her family, caregivers, and health care agents (if any) to identify strategies that might minimize or avoid the use of emergency involuntary procedures. They shall also discuss the patient's preferences regarding the use of such procedures should they become necessary. The information regarding the patient's

preferences shall be provided to the staff on the unit and shall be easily accessible in case of emergency.

9. All patients will have a physical examination and medical history completed no more than seven days before or 48 hours after admission. The admission physical shall be done in the presence of two people, the physician and a member of the nursing staff. Any remarkable scars, wounds or marks shall be recorded on the assessment form.

10. Physician orders will be written at the time of the patient admission. The Physician's Order sheet is 4 part NCR paper. It is the physician's responsibility to write the reason for the order on the right hand side of the order sheet, and to flag these new orders.

11. As a standard part of the intake evaluation, the evaluating physician shall identify whether or note the patient has any known medication allergies. This information shall be derived from the patient directly, or from collateral history supplied by family and friends, from past medical records, or from other reliable health information sources. The evaluating physician's determination shall stand until corroborated or modified by the attending physician. The final information shall be identified in the patient record. The attending physician shall inform the treatment team, nursing personnel, and pharmacy for updating patient medication information.

12. When the patient is received on the unit, the Nursing Supervisor will ensure completion of the admission nursing assessment if not completed earlier in the course of the patient admission.

13. The RN will review the physician admission orders for completeness; notifying the admitting physician immediately of any missing orders, orders needing clarification, or discrepancies with the nursing assessment. Any necessary orders or clarifications will be obtained from the physician by the RN.

14. The Nursing Supervisor will designate a staff member to begin orienting the patient to his or her room, bathroom, unit rules, and introductions to staff and other patients, if appropriate.

15. If the patient comes to the hospital with medication, all medication will be inventoried and sent to the pharmacy.

16. The admission assessment and relevant parts of the nursing flowsheet will be completed by the RN. An initial Kardex care plan will be started by the admitting RN. Additional documentation will be in the progress notes.

Guidance:

RE: Patient Allergy/Drug Sensitivity Information

- Any discrepancies between nursing assessment and physician intake evaluation related to patient allergy or drug sensitivity information will be identified promptly by the admitting nurse and resolved by the attending physician.
- Once the attending physician makes his or her determination regarding the status of patient allergies or drug sensitivities, this information shall be placed in the medical record by the physician and communicated as outlined within this policy. In addition to documentation and physician order to notify nursing and pharmacy, routine rounds shall be used to accomplish this notification.

In the event that new information is forthcoming when the attending physician is not present, the covering physician shall designate the "presumptive" allergy or drug sensitivity. Once confirmed by the attending physician, the aforementioned systems will be updated accordingly.

Approved by	**Signature**	**Date**
Frank Reed, Commissioner of DMH	Frank Reed	11/29/16